April 8, 2005

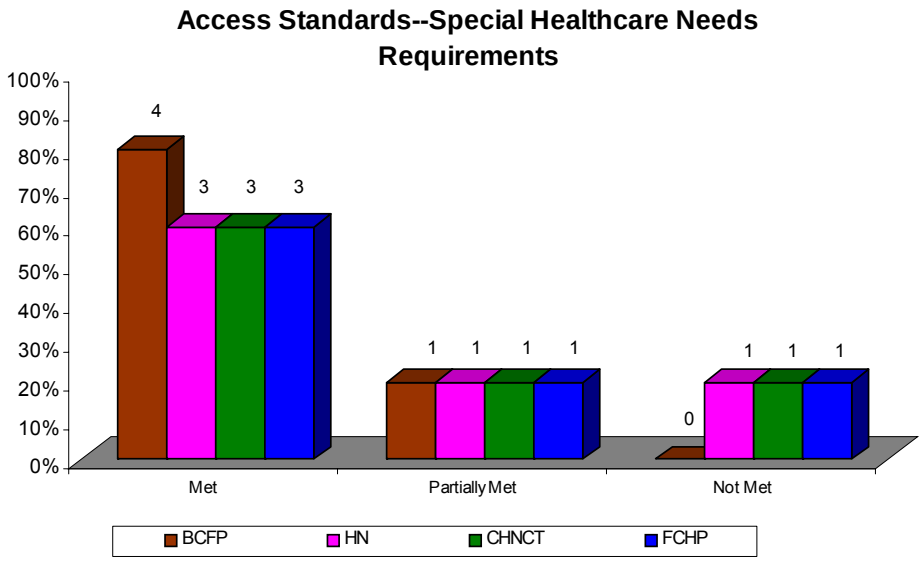
External Quality Review
State of Connecticut

Handouts

MERCER
Government Human Services Consulting

MMC Marsh & McLennan Companies

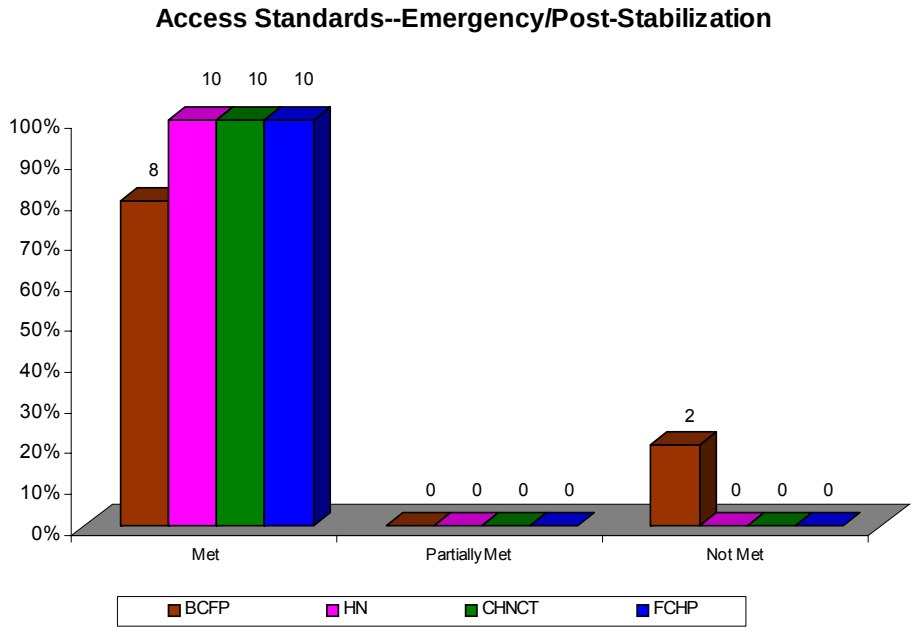
Special Healthcare Needs (SHCN) Requirements



QAPI/Access Standards — Continuity of Care Continuity and Coordination of Services					
M=Met NM=Not Met PM=Partially Met	**BCFP**	**HN**	**CHNCT**	**FCHP**	**Implications**
Special Needs Requirements					
Coordinate services furnished to the enrollee with services the enrollee receives from providers or any other organization providing health care services	M	PM	PM	PM	Interventions were consistently not timely for managing or monitoring member requirements. Assertive efforts to provide coordination of care across providers delivering services or care to a member results in care delivery that is consistent, focused toward the same outcome, avoids duplication of services, and potentially excess cost.
Shared with other MCOs, PIHPs, or PAHPs serving all enrollee needs the results of its identification and assessment of the enrollee's needs to prevent duplication of those activities	PM	NM	NM	NM	Proactive sharing of information between MCOs, PIHPs and PAHPs upon enrollee transfer or movement between plans. This supports early identification of enrollee needs, facilitates member entry into CM/DM, and avoids disruption of care or possibly an impending clinical event.
A mechanism was in place to ensure that enrollees with SHCNs have direct access to specialists, as appropriate, for the enrollee's condition and identified needs	M	M	M	M	

QAPI/Access Standards — Continuity of Care Continuity and Coordination of Services					
M=Met NM=Not Met PM=Partially Met	**BCFP**	**HN**	**CHNCT**	**FCHP**	**Implications**
Special Needs Requirements					
Implemented mechanisms to assess each Medicaid enrollee identified by the State as having SHCN to identify any ongoing special conditions of the enrollee that require a course of treatment or regular care monitoring	M	M	M	M	
Ensured that an assessment, treatment plan, and care coordination of all enrollees was being done by PCPs with enrollee participation, and in consultation with any specialists caring for the enrollee	M	M	M	M	

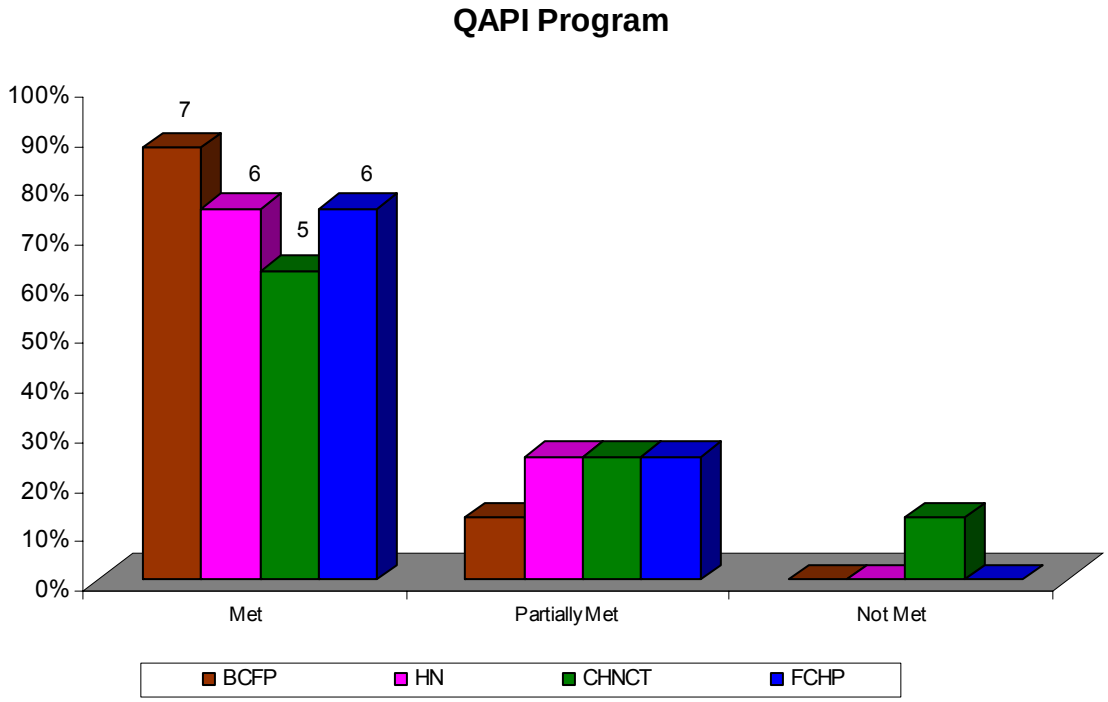
Emergency and Post-Stabilization Services



QAPI/Access Standards — Coverage and Authorization of Services					
M=Met NM=Not Met PM=Partially Met	**BCFP**	**HN**	**CHNCT**	**FCHP**	**Implications**
Emergency and Post-Stabilization Services					
Post-stabilization care services were covered and paid for when the attending practitioner actually treating the enrollee determined the enrollee was sufficiently stabilized for transfer or discharge, and this determination was binding	M	M	M	M	
Post-stabilization care services were covered and paid for when charges to enrollees for post-stabilization care services were limited to an amount no greater than what the health plan would charge the enrollee if he or she obtained the services through the health plan	M	M	M	M	
Did not use codes (either symptoms or final diagnosis) for denying claims for “emergency” conditions	NM	M	M	M	Using codes to deny services, while identified as not allowed by the BBA, also can result in an inappropriate denial of a service. An inappropriate denial could result in an appeal, which could have been avoided had the claim been reviewed by clinical staff initially.
Post-stabilization care services were covered and paid for when pre-approved by a provider or other organization representative	M	M	M	M	

QAPI/Access Standards — Coverage and Authorization of Services					
M=Met NM=Not Met PM=Partially Met	**BCFP**	**HN**	**CHNCT**	**FCHP**	**Implications**
Emergency and Post-Stabilization Services					
Any post-stabilization care services were covered and paid for even if they were not pre-approved by a health plan provider or organization representative but rather administered to maintain the enrollee's stabilized condition within one hour of a request by the treating facility for pre-approval of further post-stabilization care services; and	M	M	M	M	
Post-stabilization care services were covered and paid for even when the services not pre-approved by a health plan provider or organization representative, but administered to maintain the enrollee's stabilized condition if the health plan did not respond to a request for pre-approval within one hour	M	M	M	M	
Post-stabilization care services were covered and paid for even when the services were not pre-approved by a health plan provider or organization representative, but administered to maintain the enrollee's stabilized condition when the health plan could not be contacted	M	M	M	M	
Post-stabilization care services were covered and paid for even when the services were not pre-approved by a health plan provider or organization representative, but administered to maintain the enrollee's stabilized condition when the health plan and the treating physician cannot reach an agreement concerning the enrollee's care and a health plan physician is not available for consultation	M	M	M	M	
Post-stabilization care services were covered and paid for even when the services were not pre-approved by a health plan provider or organization representative, but were administered to maintain the enrollee's stabilized condition and the attending practitioner actually treating the enrollee determines when the enrollee is sufficiently stabilized for transfer or discharge, and that this determination was binding on health plan	M	M	M	M	
Provided hospitals, ED providers, or fiscal agents a minimum of 10 business days to notify the designated contact before a payment may be denied for a failure to provide notice	NM	M	M	M	The notification time frame allows for the recipient opportunity to provide a response or feedback to the information communicated.

Quality Assessment Performance Improvement (QAPI) Program



QAPI/Measurement and Improvement Standards					
M=Met NM=Not Met PM=Partially Met	**BCFP**	**HN**	**CHNCT**	**FCHP**	**Implications**
QAPI Program					
The description included changes that were pertinent to findings from the annual evaluation	M	M	M	M	
The description was reviewed annually to determine the impact and effectiveness of the program	M	M	M	M	
Input was obtained from beneficiaries and other program stakeholders in the development of the quality strategy.	M	M	M	PM	Including member input into quality programs is a mechanism to assure that initiatives are meaningful to members; input into strategies may positively impact identification of interventions and member compliance.
The health plan has a mechanism to detect both under- and over-utilization	M	M	M	M	
The health plan reported the status and results of their performance projects using standard measures to the State as requested. Each PIP must be completed in a reasonable time period so as to generally allow information on the success of PIPs in the aggregate to produce new information on quality of care every year	M	M	M	M	

QAPI/Measurement and Improvement Standards					
M=Met NM=Not Met PM=Partially Met	**BCFP**	**HN**	**CHNCT**	**FCHP**	**Implications**
QAPI Program					
Had mechanisms to assess the quality and appropriateness of care furnished to enrollees with SHCNs	M	PM	PM	M	Assessing the quality and appropriateness of care is essential to validate that provided services are occurring and to identify opportunities for improvement.
Quality improvement (QI) monitoring was conducted to evaluate whether the delivery of care was provided in a culturally-competent manner to enrollees	M	M	NM	M	Quality monitoring for culturally-competent delivery of services is one mechanism to assure that P&Ps and requirements of vendor contracts are being adhered to and that member's interpretive and cultural needs are met.
PIPs must be designed to achieve, through ongoing PMs and intervention, significant improvement sustained over time in clinical care and non-clinical care areas that are expected to have a favorable effect on health outcomes and enrollee satisfied	PM	PM	PM	PM	Rigorously developed PIPs may results in positive and sustainable improvements in care or services.

Performance Measures (PMs)

Summary Chart

Measure	BCFP	HN	CHNCT	FCHP	Benchmark
NICU Admits Per 100 births	8.65%	11.05%	13.86%	9.87%	National: 8-12% State average: 10.65%
ED visits Per 1,000 Member Months	648	480	696	720	HEDIS: 504[1] State average: 600
Readmission rates[2]	.78%	.66%	.88%	7.02%	State average: 1.16%
Diabetic Retinal Exams	13.38%	16.87%	12.71%	16.77%	HEDIS: 45.01% [3] Healthy People 2010: 75%[4] State average: 14.72%
Breast Cancer Screening/ Mammograms	30.80%	32.72%	32.26%	22.55%	HEDIS: 55.83%[5] Healthy People 2010: 70%[6] State average: 31.4%

Methodology was developed to measure Provider Network Adequacy, the final PM, however, due to limitations with the encounter data, the PM could not be determined in a meaningful way. Changes have been made to the encounter data warehouse which will address these limitations so that this measure can be performed in the future. A second methodology was developed to address provider demographics, which DSS felt would be of value. In future years both methodologies will be performed.

HEDIS rates are the HEDIS rates for Medicaid plans.

Notes:

[1] HEDIS rate for 1998. Standards after 1998 are highly variable using a variety of measurement types; while consensus exists that rates are going up; there is no agreement on how to measure this. Additionally, HEDIS reports that Medicaid ED visit rates are triple those of commercial plans; so a higher rate of usage is accepted. The HEDIS rate for 2004 is 49.17. HEDIS 2004 does not include rates for mental health or substance abuse. Both HEDIS 1998 (check) and the performance measure included mental health and substance abuse diagnoses in the emergency room visits rate.

[2] This rate will be tracked annually to determine if there are any significant changes.

[3] HEDIS 2004, diabetics 18-75 with a retinal exam in the measurement year or the prior year

[4] Healthy People 2010, diabetics 18 and over who had a dilated eye examination in the past year

[5] HEDIS 2004, women 50-69 with a mammogram during measurement year or prior year.

[6] Healthy People 2010, ages 40+, one mammogram within the past two years.

Performance Improvement Projects (PIPs)

BCFP

	Year				
	2001	2002	2003	Health Plan Goal	National Benchmark
Improving Outcomes in Asthma					
Use of Appropriate Medications	53.5%	56.5%	55.6%	61.0%	64.18%[1]
Members hospitalized for Asthma	9.0%	9.7%	6.8%	7.6%	7.7[2]
Members with at least one ED visit for Asthma	29.5%	29.0%	24.7%	24.0%	50[2]
Improving Outcomes in Cervical Cancer					
Improve Screening Rates	32.2%	40.6%	41.8%	42%	63.77%[3]
Improving Outcomes in Breast Cancer					
Improve Screening Rates	29.7%	32.5%	30.6%	31%	55.83%[4] 70%[5]

[1] HEDIS 2004, ages 5-56
[2] Healthy People 2010, number per 10,000, ages 5-64
[3] HEDIS 2004, percentage of women 18-64 with one or more Pap tests during the measurement year or 2 years prior
[4] HEDIS 2004, women 50-69 with a mammogram during measurement year or prior year
[5] Healthy People 2010, ages 40+, one mammogram within the past two years

HealthNet

	Year			
	2002	2003	Change	National Benchmark
Improving Outcomes in Asthma				
Use of Appropriate Medications	54.27%	62.57%	8.30%	64.18%[1]
Improving Outcomes in Adolescent Well Care				
Increase Well Care Visits	41.54%	48.15%	6.61%	37.42%[2]
Increase Adolescent Immunization Status				
MMR	70.79%	73.89%	3.10%	71%[3]
Hepatitis B	47.20%	57.58%	10.38%	56.07%[3]
Varicella	51.87%	63.17%	11.08%	44%[3]
Combo 1	43.93%	55.10%	11.08%	51.75%[3]
Combo 2	33.18%	48.02%	14.84%	33.82%[3]
Improving Breast Cancer Screening Rates				
Improve Rates	63.57%	58.04%	-5.53%	55.83%[4] 70%[5]

[1] HEDIS 2004, ages 5 – 56
[2] HEDIS 2004, ages 12 – 21
[3] HEDIS 2004, adolescents who turned 13 during measurement year
[4] HEDIS 2004, women 50 – 69 with a mammogram during measurement year or prior year
[5] Healthy People 2010, ages 40+, one mammogram within the past two years

CHNCT

	Year						
	1999	2000	2001	2002	2003	Health Plan Goal	National Benchmark
Improving Outcomes in High Risk Pregnancies							
Mothers receiving ≥81% of prenatal visits	75%	84%	83%	87%	86%	90%	48.03%[1] 90%[2]
Decrease rate of low birthweight babies	9.8%	9.6%	7.5%	9.3%	9.3%	5%	5%[3]
Increase timely post-partum visits	58%	65%	56%	63%	59%	70%	55.15%[4]

	Year				
	2002	2003	2004	Health Plan Goal	National Benchmark
Improving Outcomes in Adolescent Well Care					
Increase Well Care Visits	49.7%	53.1%	53.8%	80%	37.42[5]
Improving Breast Cancer Outcomes					
Improve Screening Rates for ages 40+	32.10%	30.21%		80%	70%[6]
Improve Screening Rates for ages 52-69	49.08%	66.67%	61.4%	80%	55.83%[7]

[1] HEDIS 2004, percentage of women receiving ≥81% of expected prenatal visits
[2] Healthy People 2010, percentage of pregnant females who receive adequate prenatal care
[3] Healthy People 2010, percentage of births with a birth weight of less than 2,500 grams
[4] HEDIS 2004, percentage of women with a post partum visit 21 – 56 days after delivery
[5] HEDIS 2004, ages 12 – 21
[6] Healthy People 2010, ages 40+, one mammogram within the past two years
[7] HEDIS 2004, women 50-69 with a mammogram during measurement year or prior year

FirstChoice

	Year			
	2002	2003	Health Plan Goal	National Benchmark
Improving Outcomes in Asthma				
Members hospitalized for asthma	112	71	None given	7.7[1]
Members with at least one ED visit for asthma	275	505	-10%	50[1]
Improving Outcomes in Adolescent Well Care				
Compliance of EPSDT screening	69%	59.33%*	80%	
Improving Outcomes in High Risk Pregnancies				
Women who have 81%+ of expected prenatal visits	Unknown	Unknown	80%	48.03%[2] 90%[3]
Women who have a post-partum visit 21-56 days after delivery	Unknown	Unknown	85%	55.15%[4]

[1] Healthy People 2010, number per 10,000, ages 5 – 64
[2] HEDIS 2004, percentage of women receiving ≥81% of expected prenatal visits
[3] Healthy People 2010, percentage of pregnant females who receive adequate prenatal care
[4] HEDIS 2004, percentage of women with a post partum visit 21 – 56 days after delivery

* These are results from 3 quarters versus 1 year.

Best Practices

- BCFP:
  - HealthReach Services, a department within the health plan, provided comprehensive outreach services to new enrollees, completing a thorough health risk assessment (HRA) process, including identification of pregnancy and newborn related issues. Some additional functions this department also provided included:
    - assistance in the selection of a PCP,
    - facilitated appointments,
    - arranged transportation if needed,
    - referred members to CM or DM, if appropriate, and
    - assessed the member or covered family member for linguistic needs.
- CHNCT:
  - Comprehensive welcome call process in which representatives spend up to a half day per week in FQHCs to contact new members.
  - The health plan included a Title Six Cultural Sensitivity document in the provider manual to inform the providers of the health plans expectations about treating members in a culturally-competent manner.
- BCFP and HN:
  - Both had in place solid practices for identifying and tracking communication to members of terminating providers. These processes included information to the member and processes for new provider selection.
- BCFP:
  - BCFP demonstrated a best practice in their care management programs. Members were stratified into programs based upon their needs and conditions. Members were stratified into population health management for those with educational needs and into CM and DM when greater interventions were required. BCFP also effectively integrates predictive modeling to assist with identification and triage members at risk in the next 12 months into the most appropriate program to meet their needs.
  - BCFP demonstrated a consistent and comprehensive strategy in the development, use, and distribution of clinical practice guidelines. BCFP interfaced with the community of providers and included member input into the guideline process. Guidelines were translated into an appropriate level and format for distribution and use by members. Information related to clinical guidelines was included in provider and member newsletters at regular intervals, and a comprehensive guideline manual was in place for provider use and reference.

Recommendations

Special Healthcare Needs (SHCN)

1. **BCFP/HN/CHNCT/BCFP**: develop a process to proactively share with other MCOs, PIHPs, or PAHPs serving all enrollee needs the results of its identification and assessment of the enrollee's needs to prevent duplication of those activities. This coordination of services is important during periods of transition when members are transitioning to another Medicaid health plan or are receiving Medicare benefits.

2. **CHNCT**: enhance CM/DM programs and better coordinate the services furnished to the enrollee with chronic diseases with the PCP and with services the enrollee receives from any other organization providing health care services to promote more timely interventions to prevent or decrease emergency department (ED) usage and inpatient admissions; more assertive follow up of information received from HRAs done by the Outreach Care Coordinators needs to be done by CM/DM staff; and members identified as having chronic disease, a more intense clinical assessment needs to be done by a nurse, the member stratified according to illness needs, and prompt interventions need to be planned and activated. Case and Disease Managers are encouraged to develop contacts with, and use, community resources more, such as health and disease outpatient education programs and disease-specific support and resource groups.

3. **FCHP**: the current process of performing outreach and assessment of new members upon enrollment is a solid baseline; in various phases in the process, more robust and assertive steps can be identified, which would allow for earlier identification and intervention of members who have high-risk or complex conditions. Review and enhance CM documentation processes to include an ongoing reassessment of the member needs with appropriate updating of members' goals and actions.

Emergency and Post-Stabilization Services

1. **BCFP**: currently using a list and administrative staff to deny cases for payment related to ED procedures; lists cannot be used to deny ED services. The current process for reviewing these services must be reviewed and adjusted to resolve this situation; develop a P&P to inform providers and fiscal agents a minimum of 10 days prior to payment denials for lack of notification.

QAPI

1. **HN**: develop an early HRA initiative to ensure that information is gathered timely to identify and interact with members with chronic diseases. Develop a monitoring process for vendors and providers to assure delivery of care in a culturally-competent manner.

2. **CHNCT/HN/FCHP**: identify a reporting format for PIPs that addresses all required components of a QAPI project, apply scientific rigor to the rationale, approach, and analysis of results, and to document chronologically the study process, goals, results, analysis, and interventions of the PIPs.

Additional EQR Activities

Special Studies: 2005

- Children with SHCNs: Access to care and utilization of services by children in foster care; and
- Childhood obesity and Diabetes II: Identification of children and adolescents with diagnosis of "overweight" and "diabetes" with analysis of care and service utilization patterns.

Activities for 2006

- MCO compliance review:
  - Quality, access, timeliness, and
  - Workplan – 2005 recommendations.
- Mystery Shopper: Access to services:
  - Assess to care from enrollee's point-of-view:
    - Appointment availability of specialty providers; and
    - Quality of customer service; and
  - Calls to providers with follow-up calls to MCOs, and initial calls to MCOs.

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